WALTHAM BEHAVIORAL HEALTH, 210 BEAR HILL RD SUITE 202, WALTHAM, MA 02451

CHILD/ADOLESCENT – PARENT QUESTIONNAIRE

Date:_____ **Form completed by:**_____ **Relationship to child:**_____

Referred by (name, telephone):_____

Name of Child:_____ Gender: M ☐ F☐ T☐ Primary Language:_____

Date of Birth:_____ Age:_____ Place of Birth:_____ Ethnic Origin:_____

Home Address:_____

Home Phone:_____ Work Phone:_____ Cell Phone:_____

Childs Primary Care Physician (name, address and phone number):_____

_____

MEDICAL HISTORY

Has your child ever had any of the following problems?	**Yes**	**No**	**When**
Seizures or convulsions			
Loss of consciousness or head injury			
Rashes or skin problems			
Meningitis			
Food allergies			
Drug or medication allergies			
Pneumonia			
Anemia or low blood count			
Heart problems			
Kidney or urinary problems			
Bowel problems			
Trouble with visions			
Trouble with hearing			
Lack of weight gain			
Poisoning or medication overdose			
Serious injury			
Hospitalization			
Surgery			
Diabetes			

Please list any other important or physical problems:_____

_____

_____

Please list any medications that our child has used over a long period of time:_____

_____

In general, has your child's health been any of the following:

☐ Excellent (rarely sick or injured, when sick recovers very quickly)
☐ Good (is not often sick or injured, illnesses are fairly short lived)
☐ Fair (frequently sick or injured, illness often linger or recur)
☐ Poor (chronically sick or injured)

Patient Name:_____

CHILD/ADOLESCENT – PARENT QUESTIONNAIRE

PRESENTING ISSUES

Please explain why you have chosen to seek counseling for your child at this time:_____

_____

_____

_____

Do any of the following apply to your child?

☐ Unhappy	☐ Irritable	☐ inflexible	☐ head banging	☐ sexual confusion
☐ drug use	☐ angry outbursts	☐ withdrawn	☐ disrespectful	☐ rocking
☐ sexual promiscuity	☐ alcohol use	☐ daydreaming	☐ fearful/phobic	☐ skips school
☐ runs away	☐ school performance	☐ suicidal thoughts	☐ awkward/clumsy	☐ overactive
☐ unkind to others	☐ atypical behavior	☐ bed wetting	☐ suicidal gestures	☐ slow/sluggish
☐ destructive	☐ poor concentration	☐ atypical thoughts	☐ soiling pants	☐ lying
☐ distractible	☐unmotivated	☐ legal problems	☐ fire setting	☐ eating problems
☐ unreliable	☐ running away	☐ peer conflict	☐ stealing	☐ sleep problems
☐ anxious	☐ impulsive	☐ self-harm	☐ often tired sick	

List any others:_____

How long have these issues existed (# of weeks, months, years):_____

Is there anything that you think may have led up to your child's current difficulties?_____

_____

_____

Has your child received counseling or mental health services before? If so, please list the name, facility and telephone number of the provider(s), dates of treatment and results:

Name	**Facility**	**Phone**	**Dates of Treatment**	**Result of Treatment**

Patient Name:_____

CHILD/ADOLESCENT – PARENT QUESTIONNAIRE

DEVELOPMENTAL HISTORY

Planned pregnancy ☐ Yes ☐ No Comments:_____

Typical pregnancy ☐ Yes ☐ No If mother was ill or distressed during pregnancy, please explain:_____

_____

Did the mother abuse alcohol/drugs during pregnancy? ☐ Yes ☐ No Describe:_____

Length of active labor:_____ Describe Labor: ☐ Difficult ☐ Manageable/easy Comments:_____

_____

Full Term: ☐ Yes ☐ No If premature, how early_____ If overdue, how late _____

Type of delivery: ☐ Vaginal ☐ Cesarean ☐ With instruments ☐ Head first ☐ Breech

Birth weight:_____lbs. ____oz. Birth length:_____

Did infant require oxygen: ☐ Yes ☐ No If so, how long?_____

Did the infant require blood transfusions? ☐ Yes ☐ No X-ray ☐ Yes ☐ No Explain:_____

Newborn Period

	Yes	No	Explain
Breast-fed (when was child weaned			
Formula-fed			
Irritability			
Vomiting			
Difficulty breathing			
Difficulty sleeping			
Convulsions/Twitching			
Colic			
Average weight gain			

Milestones

	Age
Smiled	
Sat up without support	
Crawled	
Walked	
Spoke single words	
Spoke sentences	
Bladder trained	
Bowel trained	

Patient Name:_____

During First Three Years of Life

	Yes	No	Sometimes	Explain
Illness				
Change in caretakers				
Primarily attached to one caretaker				
Enjoyed being held				
Alert to environment				
Explored environment				
Interacted with children				
Interacted with adults				
Predictable sleeping and waking patterns				
Predictable bladder and bowel movements				
Predictable hunger				

SCHOOL ADJUSTMENT/FUNCTIONING

How old was your child when he/she started daycare/preschool/other program?_____
Describe your child's experience:_____

_____

_____

School History

Name of School	Start Date	Grades Completed	Types of Classes	Child's Experience

Has your child every skipped a grade? ☐ Yes ☐ No Repeated a grade? ☐ Yes ☐ No Explain:_____

_____

_____

Has your child ever had any specific learning difficulties? ☐ Yes ☐ No Explain:_____

_____

Has your child ever had a tutor? ☐ Yes ☐ No Does your child work with a tutor now? ☐ Yes ☐ No

Is your child receiving special education services? ☐ Yes ☐ No If yes, please describe:_____

_____

Patient Name:_____

Is your child currently have an IEP? ☐ Yes ☐ No If yes, please explain:_____

_____

Has your child ever had testing at school? ☐ Yes ☐ No If yes, why/when did this occur, who conducted the testing, and what were the general results?_____

_____

_____

SCHOOL PERFORMANCE

Highest grade on last report card:___ What subject:_____ Lowest grade:____ What subject:_____

Favorite subject:_____ Least favorite subject:_____

Does your child appear motivated for school? ☐ Yes ☐ No
)

Has your child ever been suspended or expelled? ☐ Yes ☐ No If yes, please explain:_____

_____

Has your child ever had difficulty with the police ☐ Yes ☐ No If yes, please explain:_____

_____

Has your child ever appeared in juvenile court? ☐ Yes ☐ No If yes, please explain:_____

_____

Has your child ever been employed? ☐ Yes ☐ No List job, employer, and duration:_____

_____

Has your child ever had any frightening or traumatic experiences? ☐ Yes ☐ No if yes, please explain:_____

_____

_____

Has your child ever experienced any physical or sexual abuse? If so, please explain:_____

_____

_____

What are your child's strengths?_____

_____

Patient Name:_____

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Does your child have a best friend? ☐ Yes ☐ No If yes, do you think it is a healthy relationship? ☐ Yes ☐ No

If no, please explain:_____

_____

List your child's special interests, hobbies, skills:_____

_____

_____

Do you feel uncomfortable about any of your child's hobbies or interest? ☐ Yes ☐ No If yes, please explain:_____

_____

Does your child have any pets? ☐ Yes ☐ No If yes, describe type of animal, length of ownership, relationship:_____

_____

CURRENT FAMILY SITUATION

Parent #1 Name:_____ Gender: ☐ M ☐ F

Relationship to child: ☐ Birth parent ☐ Adoptive parent ☐ Relative ☐ Other (explain):_____

Birth place:_____ Date of Birth:_____ Age:____ Primary language:_____

Occupation:_____ Place of employment:_____ Education:_____

Ethnic origin:_____ Religious background:_____ Current spiritual practice:_____

Any children from previous marriages/relationships not living with you? ☐ Yes ☐ No If yes, please explain:_____

_____

Please describe any personal or family problems from your childhood:_____

_____

Please describe any current issues:_____

_____

Are you currently receiving treatment of these issues? ☐ Yes ☐ No

Parent #2 Name:_____ Gender: ☐ M ☐ F

Relationship to child: ☐ Birth parent ☐ Adoptive parent ☐ Relative ☐ Other (explain):_____

Birth place:_____ Date of Birth:_____ Age:____ Primary language:_____

Occupation:_____ Place of employment:_____ Education:_____

Ethnic origin:_____ Religious background:_____ Current spiritual practice:_____

Any children from previous marriages/relationships not living with you? ☐ Yes ☐ No If yes, please explain:_____

_____

CHILD/ADOLESCENT – PARENT QUESTIONNAIRE

Please describe any personal or family problems from your childhood:_____

_____

Please describe any current issues:_____

_____

Are you currently receiving treatment of these issues? ☐ Yes ☐ No

Status of Relationship: ☐ Married ☐ Long term commitment ☐ Separated ☐ Divorced ☐ Widowed
If one parent is deceased: Name:___ Year of Death:_____ Cause of Death:_____

Would you describe your relationship as having: ☐ No difficulties ☐ Occasional difficulties ☐ frequent difficulties

What are the strengths of this relationship?_____

_____

How would each parent describe the difficulties in the relationship?_____

_____

How are current difficulties being addressed?_____

Have you received counseling for relationship issues? ☐ Yes ☐ No If yes, please describe (include provider name and dates):_____

_____

Has the child ever been separated from either parent? (if adoption, foster care, or guardianship applies, see below):

Parent Name	**Dates of Separation**	**Age of child**

_____

_____

Describe nature of separation and child's response:_____

_____

_____

Was either parent unable or unwilling to care for the child at any time? ☐ Yes ☐ No Which parent?_____

If yes, please describe nature of difficulties and child's understanding of the situation/response:_____

_____

_____

Patient Name:_____

ADOPTION, FOSTER CARE, OR GUARDIANSHIP

Please check: ☐ Adoption ☐ Foster care ☐ Guardianship ☐ Other (describe):_____

Name and address of agency/organization involved:_____

_____

Child's State, Country of birth:_____

Child's age at time of adoption/foster care/guardianship:____Date of legal adoption:_____Pending adoption?_____

If pending, what is the status?:_____

Describe the adoption/foster care/guardianship process. Where there any complications?:_____

_____

_____

Is this an **open or closed** adoption/foster care/guardianship: ☐ Open ☐ Closed

If open, what is the nature of the relationship that you and your child has with the birth parents? How often does your child talk and/or visit with the birth parents?:_____

_____

If closed, describe your child's understanding of his/her adoption/foster care/guardianship. At what age did your child learn about his/her adoption/foster care/guardianship? Hos your child expressed a desire to learn about the birth parents?

_____

_____

_____

If your child has expressed the desire, do you support your child's interest or possible search for his/her birth parents?

☐ Yes ☐ No ☐ Don't know Explain:_____

_____

_____

Please indicate if birth relative have had any of the following:

	Birth Mother	Birth Mother's Family	Birth Father	Birth Father's Family
Allergies				
Asthma/Emphysema				
Diabetes				
Heart Condition				
Mental Retardation				

Patient Name:_____

Seizure Disorder				
Depression				
Schizophrenia				
Other Psychiatric disorders (explain)				
Learning Disability				
Behavioral Problems				
Alcohol/Drug Abuse				

Living Arrangements

Number of moves in child's life:_____

Location **Dates** **Reason**

_____

_____

_____

_____

Current home: ☐ House ☐ Apartment ☐ Renting ☐ Own What year did you move into your current home?_____

Does the child share a room with anyone else? ☐ Yes ☐ No If yes, with whom?:_____

_____

Please list information about the child's siblings below:

Name	Age	Sex	Living at Home?	Receiving Mental Health Services?	Drug or Alcohol Problems?	Birth/Adoptive/ Stepsibling/Other

Besides the child and the siblings above, who else lives in the family home at the present time?

Name	Age	Sex	Relationship to the Child	Receiving Mental Health Services?	Drug or Alcohol Problems?	Physical Illness

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Is there anything else that would be important for us to know in order to best meet the needs of your child and your family?_____

_____

_____

_____

_____

_____

Patient Name:_____